
Individualized Plan of Care instructions apply to any participant on the Adult DD, Children's DD, or ABI Waiver. This manual also includes guidance and instructions for all supplemental forms and documents relating to the IPC approval process.

Examples and prompts are provided in the IPC and in the instructions to initiate team discussion and capture specific details about the participant's supervision and support needs. Descriptions in the plan should be uniquely developed for the participant.

Forms, instructions, memorandums, samples, training notices, and other waiver items are available on the Division's website:

<http://health.wyo.gov/ddd>

Individualized Plan of Care (IPC) INSTRUCTIONS

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PLAN OF CARE REQUIREMENTS

These instructions shall be used to develop the Individualized Plan of Care (IPC) with input from the participant and team. All sections of the plan of care are important and shall be specifically written to reflect the participant's needs, goals, medical condition, health and safety needs, and/or behavioral concerns.

The Individualized Plan of Care (IPC) shall be submitted 30 calendar days before the intended start date. If an ECC request is submitted with the plan, then it shall be submitted 40 calendar days before the intended start date.

Plans submitted without a guardian's signature shall be considered "Incomplete" and shall not be reviewed until the signature is submitted. In extraordinary situations, the case manager shall work with the waiver specialist on a time period for submitting the necessary signatures. Incomplete plans submitted to the Division, even if received on time, will be considered "Late". If it continues to be an issue with other plans, it will be considered a certification issue.

The participant's legal name must be on the top of each page. The locked version of the plan does not allow for "fill-in" text in the header, so a text box is provided to fill in the name on each page. The unlocked version of the plan will allow for header access, but the Division prefers that case managers use the locked version for consistency in plan submission.

If all components of the plan are complete at the end of the team meeting, the team shall sign the plan at this time. However, if the team is making changes to the plan after the meeting, then team members must sign it after the changes are completed. The Division has final approval of the plan. If there are changes to the plan during the approval process, the case manager shall notify all team members.

The Case Manager will assure all direct care providers on the plan receive training on all components of the plan of care and any changes to the plan made during the year. At the team meeting, the team will identify and document who is responsible for training team members and staff on the plan or changes to the plan. If both self-employed providers and organizations are on the plan, then the case manager shall help coordinate the training between all parties.

PLAN OF CARE SECTIONS

About Me

1. Use a person-centered planning approach to assist the participant to receive the supports and services he/she needs to accomplish personal goals. Responses should portray a comprehensive picture of the participant, so the team and staff working with him/her will understand how to deliver services and supports around his/her individualized needs and preferences.
2. Use appropriate language for responses:
 - a. Answer in the first person, or use direct quotes, whenever possible.
 - b. If the participant is non-verbal use wording like “My mom says I” or “Jane Doe, my guardian, says...”
 - c. If the team has additions to the statements, add information stating: “The team believes Jane ...”
3. The About Me questions can be answered before the IPC meeting at monthly case manager visits or with help from staff, but should be *reviewed* at the team meeting.
4. Answer all questions with complete sentences.
5. For the first question, give a detailed summary of progress on habilitation objectives in addition to achievements, special events, and personal goals of the participant.
6. Preferred activities identified in the About Me section should be reflected in schedules.
7. Include health and safety considerations.
8. Responses should reflect psychological/medical recommendations as appropriate.
9. Address any transition in the future.
10. Children’s Waiver considerations:
 - a. If a child will be turning 18 within the next plan year, be sure to include whether or not guardianship is being pursued.
 - b. Include plans for day activities if the child will be leaving school.
 - c. NOTE: Children’s Waiver does not pay for Day Habilitation or Employment Services.

Demographics

1. Accurate information is essential. Complete all applicable information or mark “no”, if a section does not apply.
2. Use the participant’s legal name. Then list preferred name, if applicable.
3. Enter complete addresses including street, P.O. Box, City, State, and Zip Code.
4. Document the Individual Plan of Care Team Meeting Date and Plan Start Date.
5. List the date of the current Psychological Evaluation, current ICAP score, and date of ICAP.
6. If the demographic information changes, such as an address, guardian name, or phone numbers, the case manager must submit an updated demographic page within 30 days.

Functional Limitations

1. A minimum of three areas must be identified for a participant to be eligible for waiver services.
2. Select items specific to the participant’s current limitations.

Rights, Responsibilities and Restrictions

1. Rights of the participant are detailed in the “**Rights, Responsibilities and Restrictions**” document available on the Division’s website, and shall be made available and explained to the participant, guardian and/or parents. Record the date that the document was reviewed.
2. Rights listed on the page may be modified for the participant by the guardian, along with the team.

3. If physical restraints or mechanical restraints are used on a participant, then the appropriate box on the page shall be marked and it must be listed as a restriction of rights.
4. Rights are listed in the table on the page. Mark if right is restricted and identify:
 - a. **The reason for restriction**
 - i. Right may need restricted due to health & safety concerns, behavioral modification, and/or guardian preferences.
 - b. **How is restriction imposed**
 - i. Restriction may be through a protocol in the behavior plan, through a contractual agreement, court order, staff supervision due to health and safety, etc.
 - c. **How will my team help me exercise this right more fully?**
 - i. List strategies that can encourage more independence with the specific right. Examples could include a less restrictive protocol, objectives to teach the right, behavior plan to lessen problematic behaviors, environmental accommodations. These activities may help participant work towards less restriction (*such as standing outside the bathroom instead of inside the bathroom*).
 - ii. Some participants may always have some restrictions, but some restrictions may be lessened over time.
 - d. **NOTE:** Specific rights can be restricted for more than one reason.
 - i. For example, an individual may have limited access to cigarettes due to health reasons, but may also have a temporary removal of possessions for behavioral modification purposes.
 - ii. If this is the case, mark more than one box. Give additional information on EACH restriction, including how it is imposed and how will the team assist the participant to exercise the right more fully.
 - e. **Date to review restrictions-** The month and year are required and should be reviewed at least every six (6) months.
5. **Guidance on Specific Rights**

The following information is not meant to cover all possible questions on rights and restrictions, but serves as a guideline. If there are specific questions, the case manager shall consult with the Waiver Specialist and the Waiver Manager.

 - a. There are differences between the rights of children and adults.
 - b. If the plan is for a child, then:
 - i. Parents usually exercise control of the rights of children. Based on this, it is not necessary to list rights restrictions for children under 18, unless:
 1. A child is 8 or older and needs assistance in the areas of toileting and bathing.
 2. A child is 8 or older and has either a video or auditory monitor in the bathroom or bedroom.
 3. A behavior program for any age child that lists restrictions that providers would be expected to carry out.
 - ii. Wyoming law considers all persons 18 or older as adults.
 - iii. Applicable rights restrictions must be documented for participants 18 and over regardless of waiver, even when there is a guardian appointed.
 - c. **Right to keep and spend money**
 - i. List as a restriction, if:
 1. The participant has a representative payee
 2. The participant has a conservator
 3. The money is withheld as a consequence to a maladaptive behavior

4. The participant's account requires two signatures
- ii. Do not list as a restriction, if:
 1. The organization has a policy in a Participant handbook or another format on:
 - a. Safeguarding money
 - b. Reporting finances to the guardian and case managers
 - c. Room and Board
- d. Right to keep and use personal possessions**
 - i. List as a restriction, if:
 1. Possessions are locked up by the provider
 2. Access to cigarettes, chewing tobacco, or alcohol is limited – even if it is for health reasons
 3. There is temporary removal of possessions, such as clothing, bedding, games, toys, books, crafts, movies, CDs, etc. for behavioral modification purposes.
 - ii. Do not list as a restriction, if:
 1. Personal possessions are specifically locked up by a participant's wish.
 2. Possessions have guidelines for use as chosen by the participant or guardian.
- e. Right to access to food or drinks**
 - i. List as a restriction, if:
 1. The participant is on a restricted calorie diet or doctor-ordered diet, and there is no flexibility in the diet, or deviations would result in significant health risks.
 2. Food or beverages are locked up due to health and safety concerns, either for the participant or any of his/her housemates.
 - i. NOTE: This should be used very sparingly – usually only for Prader Willi syndrome, or similar eating disorder/conditions.
 - ii. Cannot be used for staff (supervision) convenience
 3. Food or beverages are restricted due to a positive behavioral support plan when the participant does not have a choice in food/beverage selection or quantity.
 - ii. Do not list as a restriction, but under the “**My Supports**” section or on a separate protocol:
 1. Foods, snacks, or beverages are specifically listed by a participant's wish
 2. Caloric or other food guidelines as chosen by the participant
 3. If the organization has posted menus and substitutions are allowed
- f. Right to send and receive unopened mail**
 - i. List as a restriction, if:
 1. A participant's mail is screened.
 - ii. Do not list as a restriction, if:
 1. Assistance is given to individuals who cannot read
 2. If the organization has policies dictating mail comes to a central location
 - a. This should be explained in the Participant
- g. Right to make and receive telephone calls**
 - i. List as a restriction, if:
 1. The receiving or making of calls are restricted.
 2. The receiving or making of calls are restricted due to guardian request.
 - ii. Do not list as a restriction, if:
 1. Assistance is given with phone calls, if the person can say no.
 2. If there are program policies, such as calling while at work, times that calls are allowable, payment for calls, use of cell phones, etc.

- a. These should be listed in the Participant Handbook
- h. Rights to privacy in matters of activities of daily living**
 - i. List as a restriction, if:
 - 1. Assistance is needed in bathing and toileting for anyone over the age of eight (8) years old.
 - 2. Audio or visual monitors are used in the restroom or bedroom of a residence, for anyone over the age of 8, regardless of intent. *(Even if the monitor is used for seizure safety, it is still a restriction of privacy)*
 - a. For any restriction in privacy, the “How imposed” section must include procedures to ensure dignity and as much privacy as is safe for the person
 - ii. Do not list as a restriction:
 - 1. Audio or visual monitors used in common areas, such as exterior doors, day program sites, or in residential areas where more than one person congregate.
 - a. The use of monitors should be noted in the Participant Handbook or in other documentation to assure people are aware conversations may not be private.
 - b. It should be noted in the “**My Supports**” section.
- i. Right to receive visitors and communicate and associate with persons of one’s own choice**
 - i. List as a restriction, if:
 - 1. There is a court order, custodial rights, or condition of probation.
 - 2. The participant has an approved visitors list.
 - 3. Due to behavioral issues, the choice of others in the home is restricted
 - a. Plans of the others in the home may need to have right restricted, if a restriction of visitors limits their right as well
 - ii. Do not list as a restriction, if:
 - 1. Organizational policy limits number of visitors, has sign in procedures, has structured time for visits, etc.
 - a. These should be listed in the Participant Handbook
- j. Right to be free of mechanical or physical restraint**
 - i. **Mechanical restraint.** Any device attached or adjacent to a Participant’s body, which he or she cannot easily remove, and which therefore restricts freedom of movement or normal access to the body.
 - 1. List as a restriction, if the mechanical restraint is a:
 - a. Item such as weighted blanket/vest/body sock and participant cannot remove the item on his/her own, unless the item is used in an approved therapeutic program.
 - b. Lap belt, strap, glove, or other item, which restricts movement of the body due to behavioral considerations and participant cannot remove the item.
 - 2. Do not list as a restriction the following mechanical restraints, if used for standard safety reasons, such as:
 - a. Seatbelt/car seat
 - b. Wheelchair lap belt
 - c. Specialized harness, car seat for adult, safety belt, head supports, bed rails, etc.
 - i. These should be listed under “**My Supports**” and “**Specialized Equipment List**” in the plan with the maintenance check identified.
 - ii. **Physical/Personal restraint** means the application of physical force without the use of any device, for the purposes of restraining the free movement of the body of the Participant.

1. List as a restriction, if a physical restraint or release is used.
2. Do not list as a restriction but a “community support”, if the action is:
 - a. Holding a person’s hand to cross the street safely
 - b. Helping a person get in to or out of a place
- iii. **A drug used as a restraint** is not allowed to be in a participant’s plan of care.
 1. PRNs used for behavioral modifications, which are prescribed by a medical professional, must be part of a participant’s standard treatment plan for his/her diagnosis or medical condition. These drugs are not considered restraints when used as prescribed.
 2. If a drug is used on a participant to restrict free movement of the body, but it is not a part of the participant’s standard treatment plan, it is considered a restraint. The Division will not allow waiver providers to administer chemical restraints.
- k. **Right to choose with whom and where to live *and* Freedom to move in and outside of the residence**
 - i. List as a restriction, if:
 1. The participant has a guardian and is over 18 years old
 2. The participant is prevented from leaving as a consequence of a maladaptive behavior
 - ii. Do not list as a restriction:
 1. A tracking bracelet, unless it is court ordered and the participant has limits on where he/she can walk.
 2. A video monitor or sound alarm on exterior door and works as a notification that additional assistance is needed
 3. A fence, or
 4. An item used to block access to stairwells or unsafe areas due to safety concerns.
- l. **Right to choose providers of waiver services**
 - i. List as restriction if the individual has a guardian and is over 18
- m. **Right to choose own medical services**
 - i. List as restriction if the individual has a guardian and is over 18

Services Available

1. The services selected on this page must match the services listed on the Pre-approval Form;
 - a. Note that some Services are available only to specific waivers, (i.e. S-5130 Homemaker *Children only* and Supported Living Service *Adult* and *ABI only*)
2. Identify Non-Waiver Services
 - a. By marking the appropriate box, and
 - b. Listing any additional non-waiver services under “other”.

Medical Services

1. List last annual physical date, which is covered by Medicaid, and physician’s name.
2. List last annual dental cleaning date, which is covered by Medicaid, and the dentist’s name.
3. List last eye exam and the optometrist name.
4. List any other specialty exam needed or received, such as a mammogram, colonoscopy, liver function test, blood tests, PSA, etc. Name the medical professional(s) used.
5. For all services applicable, list the recommendations for visits or ongoing treatment; date of last visit; projected date of next visit.
6. Identify who will assist the Participant with medical appointments. If a nurse must attend, this must be supported in the Physician’s order.

Medical Information

1. Identify all primary physician information.
2. List all documented diagnoses from psychological/neuropsychological evaluations and medical diagnosis if appropriate. This box will expand.
3. Complete information on allergies, including any food, medicine, seasonal, pet, or other allergies.
4. Provide information on serious allergic reactions which may occur, so a provider knows what to expect or can notice symptoms should they occur. These may be a blocked airway, mild rash, hives, vomiting, etc.
5. Specify if immunizations are current. These vaccines may include influenza, pneumonia, shingles, tetanus, hepatitis, DPT, HPV, etc., which are Medicaid covered services. Indicate if seasonal immunizations are planned.
6. List medications used as of the time the plan is written.
 - a. Case Managers shall verify that providers who provide direct care have current medication information.
 - b. If the Participant lives with his/her family, the family is responsible for notifying the case manager of all medication changes.
 - c. The case manager is responsible for updating all team members on medication changes.
 - d. All sections of the medication table shall be filled out, no blanks or “unknowns”.
7. The question “If psychotropic/seizure medications are given, identify the medical professional responsible for monitoring the medications” must be answered in this box, if applicable. Blood tests and/or liver function tests should be done every three months or as determined by the medical professional to test for side effects.
8. In the next box, “Specify any pertinent medical or health issues and any potentially risky behavior related to medication or medical treatment” include:
 - a. Any information or instruction for current medical or health concerns. The box is expandable.
 - b. Protocols for PRNs in this area including non-prescription/over the counter medications (*unless a PRN for behavioral modification is listed in the positive behavior support plan*), including:
 - i. Who notifies the appointed person to do the assessment for the need of a PRN,
 - ii. Who administers the PRN,
 - iii. Who monitors the participant for side effects after it is taken,
 - iv. How is PRN documented, and
 - v. Who analyzes the use of the PRN.
 - c. Pertinent historical information related to current medical or health concerns, but do not include:
 - i. Past history, which is relevant *only* to the psychological evaluation, or
 - ii. Information on incidents *unrelated* to medical or health concerns
 - d. Any potentially risky behavior related to medication or medical treatment, including:
 - i. Tendencies to pocket pills, aspirate on medication, skip medications, refuse medications, take them later than scheduled time, forget medications, etc.

Medical Assistance

This section addresses medication assistance by waiver providers. If the family assists with all medications, mark the 1st box. However, if providers are expected to assist with medication AT ANY TIME, this section must be completed.

1. Verify the assistance, if any, is needed by the participant to take medications. If no assistance is needed then the section does not need to be completed.

2. If the participant needs assistance both by a provider and a skilled nurse, delineation must be made. The justification submitted is subject to approval of the Division and must distinguish between the areas of provider responsibility and duties that only the skilled nurse can assist.
3. Check the areas of assistance needed by the participant (*Division standards, policy, procedures shall be followed if a provider assists the participant with medications.*)
4. In the space provided after an assistance box is marked, offer instructions for the provider and the skilled nurse. Assistance shall be consistent and appropriate for the participant's ability level.
 - a. Examples for instructions may be these type of descriptions, but must always be personalized for the participant's specific needs:
 - i. **Physical Assistance:** "Take my pills from storage, check to see if my pills are correct according to my Medication Assistance Record (MAR), ask me to open my mouth, place pills in my mouth, ask me to swallow, give me a drink through a straw, and check my mouth to assure I have swallowed them."
 - ii. **Package Assistance:** "Remove the pills from the med organizer and put in a small cup."
 - iii. **Verbal prompt:** "Remind me when it is time to take meds."
 - iv. **Visual Monitoring:** "Make sure I have washed my hands, have a clean area to check my meds in the box, confirm the pills I shall take, and have a drink ready to help swallow. Check my mouth afterwards to assure I have not pocketed pills or failed to swallow one."
 - v. **Demonstration needed:** "Show me how to tilt my head back and put the pills in my mouth."
 - vi. **Storage, Access, and Documentation:** "Help me assure that the correct bubble pack is opened for the correct day and time, then help me document the time I took the pills."
5. If the participant has a special medical treatment or procedure, a protocol should be developed and it shall be noted in this section. All providers, who are expected to perform these treatments/procedures shall be trained. Special treatments or procedures may include vagas nerve stimulator, psoriasis, acne, etc.
6. If risks relating to medications or medical procedures is noted in the previous section, then a description of the "**safety plan**" to mitigate and prevent the risks shall be outlined. Example may be, "When I take my pills, staff asks to see the inside of my mouth after taking medicine and check my hands after I take my medicines to assure I am not pocketing pills in my cheeks, under my tongue, in my hands or clothes."
7. Identify the assistance needed for medical appointments. Outline transportation arrangements needed for medical appointments, who arranges the medical appointments, and other instructions to meet the participant's needs in this area.
8. "**Health Education...**" is important for certain age groups, people with certain predispositions to medical problems, and those with unhealthy habits. Use this box to describe any recommended health education needs a participant has been given by a medical professional and name the responsible party for offering the education.
9. If the participant has special instructions for medical appointments, which make the participant more comfortable, list the strategies or actions providers should take to help facilitate this process.

Seizure Information

1. If the participant has seizures, complete the information in this section as fully as possible, no blanks will be allowed. If the participant does not have seizures, mark “no” and skip this section.
2. The Waiver Specialist may request a seizure protocol, depending on the severity of the seizure disorder.

Specialized Equipment List

1. List all equipment purchased with waiver or public funds within the last plan year, along with any equipment that is still in use.
2. Include equipment purchased with Medicaid funds. For example, if a wheelchair was purchased with Medicaid funds 3 years ago and is still in use, it should be listed.
3. If the Participant does not have specialized equipment, draw a line through the page or mark N/A.
4. If there is more equipment than the number of boxes, the last row is expandable or another sheet may be attached.
5. List any needed adaptive equipment/assistive technology and the action plan and time frames for requesting and obtaining this equipment.
6. List equipment that is no longer of a benefit and the reasons why it is not.
 - a. The Weston Center accepts donated equipment as well as other places. Equipment in this Center is available for any Wyoming citizen to check out.

My Services and Supervision Profile

1. Answer the questions in first person or state who is responding, such as “My team, or my mom...”
2. Choose the box that best describes the living placement of the participant, such as family home, apartment with roommate(s), group home with ☒ other housemates, etc. Use the box marked “Other” to describe family situations such as joint custody, weekly home visits with family, etc.
3. List all of the waiver services provided to the participant in the home.
4. Identify how the participant spends his/her day. Describe waiver services, non-waiver services, school, work, and/or other regular social and volunteer activities. Include average number of hours in each service.
5. Explain behaviors the participant has a tendency to exhibit in the home or day site that may put the health and safety of the participant or others around at risk of harm. This section does not replace a positive behavior support plan if one is necessary. Examples of behaviors addressed in this area may include:
 - a. “I may try to elope from the facility when I am mad.”
 - b. “I am at risk of sexual exploitation due to inviting many friends and unknown people into my home against my team’s wishes.”
 - c. “I may pick items out of the trash or off the floor to eat.”
6. Explain behaviors the participant has a tendency to exhibit in public places that may put the health and safety of the participant or others around at risk of harm. This section does not replace a positive behavior support plan if one is necessary. Examples of behaviors may include:
 - a. “I have sensitive skin to sunlight and burn easily. I exhaust myself within one block of walking and will start sitting down and refusing to move.”
 - b. “In stores, I may try to shoplift if no one is watching me. I have been charged with this offense in the past.”
 - c. “I am at risk of financial exploitation due to buying items and not waiting for my change. I also may give my money away to anyone who asks.”
 - d. “I may start hitting others or vandalizing due to a lack of attention or not getting my way.”

7. Develop strategies that the team will use to help the participant be safe. Examples of strategies relating to the behaviors listed above may include:
 - a. "I will have my wheelchair with me if I need to walk for distances over one block or when I have to stand for more than 10 minutes at a time."
 - b. "My team will try to redirect me when I get upset and ask me to talk about what is making me mad. If I walk out of the building, staff will follow me."
 - c. "I will stay within an arms length of staff inside stores. Staff will also check my hands periodically and ask me to help with putting items in the cart to keep me busy."
 - d. "My team will train me on safe people who can visit my home and people who are not safe. My team will educate me on safe boundaries and how to access emergency services."
 - e. "My team will keep trash covered, empty household trash twice a day, and keep small objects and food off of the floor. If I start trying to eat things that are unsafe, they will engage me in a hands-on activity."
 - f. Every provider who works with the participant shall follow these strategies and the positive behavior support plan, if there is one.
8. **"Describe my supervision/supports..."** shall be a specific narrative, including details about the participant's supervision and support needs, and various situations where the supervision level is different (more or less intensive).
 - a. **Example for a participant in a group home:** "I need staff within eyesight in all areas of the home except my bedroom. When I am in my bedroom, I need 30-minute checks for safety. If I go into the community, I need to stay within 10 feet of staff and always within eyesight. If food is present, staff should be within an arm's length. Due to support needs, I need 1:1 assistance in the bathroom and in the kitchen."
 - b. **Example for a participant living semi-independently:** "I need staff to help me plan and cook meals, keep my apartment clean, get to appointments, and follow my schedule. Outside of these activities, no direct supervision is needed at home or in public places."
 - c. **Example for a participant living with family:** "When I am with my provider in the community, I require a staff within an arm length. At home, I can be within a safe proximity of my provider."
9. If a participant needs assistance or monitoring during sleeping hours, explain how staff will assist with positioning, transfers, hygiene, visual checks, brief checks, or other supports needed to stay safe. Also include any equipment used, frequency of support, and documentation requirements.
 - a. NOTE: Only participants who have a medical or behavioral concern during nighttime/sleep hours should have monitoring or assistance during these times. Nightly checks are often disruptive to a person's sleep. The participant shall have the utmost privacy, even when some monitoring or support is needed.
10. If the participant receives residential or day habilitation, mark the participant's approved staffing ratio. **"Supervision levels"** are described in the *IPC Instructions*.
11. If Intervention Hours are used, specify the service where it is used, how the additional staff person for intervention is accessed, and for what the intervention will be utilized. *Refer to Figure A-2 for clarification on appropriate uses for intervention hours.*

Employment Interests, Activities, and Support

1. Participants, who work or receive reimbursement for work activities at day habilitation, shall answer the questions in this section.
2. Describe the participant's work or job; list the place of employment and average work hours a day.

3. Mark if the participant receives waiver services to support him/her at work. Describe the supervision needed at work or during training. Include natural supports, co-worker supports, or other people who help assist in supervising or supporting the person at work.
4. List the accommodations needed, such as a stool, back brace, breaks each hour to stretch, refocus prompts occasionally, etc.
5. Ask the participant if he/she likes the work he/she does. Record the comments made about his/her job satisfaction.
6. Explore other ideas for work or jobs if he/she expresses interest in wanting other work or if the team identifies that the participant has the potential for learning other types of work.
 - a. The team shall develop strategies to help the participant explore these ideas or arrange job shadowing to allow the participant to learn more about the type of work.
7. To answer the questions regarding the payer of supported employment services, consider the following information:
 - a. **Division of Vocational Rehabilitation (DVR) will not pay if:**
 - i. The job is in a non-integrated environment, where more than half of the employees do not have disabilities (such as facility-based work), or
 - ii. The participant *does not want* community-based, integrated employment.
 - iii. If a participant has a community job or wants to pursue community employment, complete the questions in the plan concerning DVR
 1. The participant should contact DVR to verify that his/her desired employment would or would not qualify for DVR services.
 2. Participants, who are not able to access services without assistance, may have the guardian or case manager contact DVR on his/her behalf to set up an appointment. If a participant has another person assist with contacting DVR, then a Release of Information from DVR to the 3rd party is required from the Participant or Guardian, if there is one.
 - a. DVR may be able to assist the person with supported employment services, but the participant, and 3rd party if necessary, must attend appointments consistently to ensure successful employment outcomes.
 - b. **Waiver will pay if:**
 - i. DVR closes the case and the participant still requires supported employment to maintain the current employment position.
 - ii. The job is located in the community or in a business that is part of a provider organization, such as an enclave, where the person is paid at or above minimum wage.
 - iii. The need for supported employment is justified in the plan of care and the participant's budget will allow for the units requested.
 - c. **Waiver will not pay if:**
 - i. Supported employment services can be provided by DVR.
 - ii. The participant is making below minimum wage. If the participant receives reimbursement for habilitation objectives during day habilitation services, then a fair and equitable wage is determined by the provider for the tasks performed.
 - iii. Services are for transportation assistance only and no habilitation is needed.
 - iv. Reimbursement is for incentive payments, subsidies, or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize employer's participation in a supported employment program,
 - v. Payments are passed through to beneficiaries of supported employment programs; or

8. Payments are for vocational training not directly related to a supported employment program.
9. Answer the questions regarding payer of supported employment thoroughly and record the date of the last DVR contact or appointment. This section documents that DVR was considered or used as a payer of supported employment services, as required under the Rehabilitation Act of 1973, section 110 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) and is required to be in the participant's file per CMS regulations.

My Supports

1. Each section must be addressed. For each section, check each appropriate box that applies to the Participant.
2. More than one box can be checked in each section, but if more information on the participant's needs should be listed, then use the fill-in boxes available to capture the information.
3. Address behaviors or conditions that pose a health and safety risk to the person in the supports area where specified. Also, include safety plans for those identified risks in the areas provided.
 - a. An example in the Mobility area may state, "I am at risk of falling when I first stand up."
 - b. The safety plan may be, "Staff will teach me/remind me to ask for assistance before standing, and I will hold staff's forearm when getting up, and hold on to staff or furniture during the first few steps I take."
4. Mealtime guidelines represent formal guidelines that have been developed by a physician, nurse, dietician, or speech therapist to assist the Participant with safe eating protocol (because of feeding tube, swallowing problems, aspiration risk, etc.).
5. Dietary questions address nutritional guidelines that can be formal or informal.
 - a. Guidelines may be in place for health reasons, such as restricted calories due to obesity, diabetic diet, doctor-ordered diet, etc.
 - i. List the reason for these guidelines.
 - ii. If an individual has no choice in the diet, it should be listed in the Rights Restrictions.
6. Supports needed by a participant should also be reflected in his/her schedules, with a description of the specific supervision or type of support needed in various activities.

Positive Behavior Support Plan

1. The positive behavior support plan shall be included, if applicable, after the "My Supports" page.
2. The positive behavior support plan shall be developed for:
 - a. Any behavior listed as moderate or above on the current ICAP.
 - i. If these behaviors are no longer a problem, then the case manager will need to explain the reasons for not addressing the behaviors in writing when submitting the plan of care.
 - b. Specific behaviors identified by the team or psychologist that need to be changed or eliminated
 - c. Behaviors identified as health and safety concerns
 - d. Behaviors identified as barriers to gaining independence, employment, or positive social interactions within the community
2. The team should address possible medical reasons for the behavior.
3. A team and/or psychologist may draft a positive behavior support plan to address any behavioral concerns of the Participant, in which case, the case manager shall coordinate with a psychologist when needed, or when the team is having trouble designing a behavior plan.
4. Case managers are responsible for assuring providers are trained on the positive behavior support plan before they begin working with the Participant.
5. The targeted behaviors may be prioritized by the most critical or important behaviors first, and others addressed as needs change.

6. The positive behavior support plan shall:
 - a. Be person-centered,
 - b. Have the participant involved in the development of the plan on a level appropriate for that person, and
 - c. Maintain the dignity and respect of the participant.
7. The positive behavior support plan shall include (*items in bold*):
 - a. **Information based on the functional behavioral analysis** of targeted behaviors, which:
 - i. Does not have to be submitted with the Plan of Care, but
 - ii. Shall include the following components:
 1. A brief history of the participant as related to the identified behaviors
 2. Descriptions of direct observations of behavior
 3. Information on antecedents to targeted behaviors that providers are aware of, so they can intervene and/or assist the person in replacing the targeted behavior with a replacement behavior
 4. Information on baseline data collected, if possible, which more thoroughly describes the targeted behaviors, including frequency, severity, etc.
 5. Identification of replacement behaviors or approaches that assist the participant in getting needs met in an appropriate way
 - iii. A Sample of a Functional Behavioral Analysis is available on the Division's website.
 - b. **Targeted behaviors:**
 - i. Description of each target behavior and its brief history
 - ii. Reason the team believes target behavior occurs
 - c. **Directions for provider:**
 - i. To recognize antecedents and emerging targeted behaviors
 - ii. To intervene in a positive, least restrictive, and most effective manner when targeted behavior emerges
 - d. **Positive behavioral supports:**
 - i. Statements or cues staff should use to communicate and/or intervene with the participant
 - ii. Actions to assist the participant in replacing targeted behaviors with replacement behaviors
 - iii. Positive supports and interventions, which may include:
 1. Strategies to preteach or model actions before an event or environment so targeted behaviors can be prevented.
 2. Preventative measures staff can take to adjust the environment once preliminary behavior is displayed. (*Such as changing rooms, turning off noisy items, distancing other people from the person, removing the person from a problem event, etc*)
 3. Positive intervention steps staff should try once the preliminary behavior is exhibited. (*Such as key phrases, options, choice for/modifying/ending an activity*)
 4. Cues to introduce tasks or choices that promote replacement behaviors.
 5. Evaluating what the person is trying to communicate by showing this behavior, due to past evidence, and try to meet the person's needs. (*Such as taking him/her to the bathroom, giving him/her time to calm down, offering a change in environment, etc.*)
 - e. **Replacement behaviors:**
 - i. A more desired behavior the participant should do instead of the targeted behavior
 - ii. Directions to teach, model, or prompt the participant to initiate the replacement behavior
 - f. **PRN information** for behavioral modification, if applicable:
 - i. If PRNs are listed on the "**Medical Information**" page and are used to handle behavioral issues, then the PRN protocol in the positive behavior support plan should include:

1. Who notifies appointed person to assess the participant for a need of a PRN,
 2. Who administers the PRN,
 3. Who monitors the participant for side effects after it is taken,
 4. How the PRN is documented, and
 5. Who analyzes the use of the PRN.
- g. **Restraints**, if necessary:
- i. An order for the use of a restraint by a physician or designated, trained, and competent qualified behavioral health practitioner shall be submitted at least annually.
 - ii. Restraints listed in the behavior plan should also be included on the restriction of rights page of the Plan of Care.
 - iii. Restraint usage must be in compliance with Chapter 45, Section 28, including:
 1. The least restrictive intervention techniques, which should be used prior to the use of restraint.
 2. Any limitations or specific descriptions of the proper restraint to use or not use on the participant.
 3. The designated staff to provide face-to-face evaluation of the participant within one hour of the use of restraint.
 4. Providers shall receive training on the use of restraint from entities that are certified to conduct such training before agreeing to provider services for that participant.
- h. **Therapeutic actions/interventions:**
- i. Provider actions that should occur following the targeted behavior, and
 - ii. When should they occur
- i. **Review:**
- i. Protocol for who will review plan (at least quarterly) for effectiveness, how often, and who will revise the behavior plan as necessary
- j. **Documentation:**
- i. Specific documentation shall be developed and may be requested by waiver specialist for:
 1. Tracking the occurrence of targeted behaviors, and
 2. Tracking results of positive behavioral interventions
 3. Tracking use of PRNs, restraints, and restrictions.
 - ii. Documentation shall include:
 1. Dates and times of the occurrence of the targeted behavior
 2. Description of the antecedents to the targeted behavior
 3. Trend analysis on the behaviors and incident report information
8. When behavior support plans include rights restrictions, the plan shall include information on temporarily lifting the restriction during times of personal crisis, when appropriate. Times of crisis may include a funeral, family emergency, health concern, etc.
9. When the behavior plan includes a restriction from community activities, it shall:
- a. Not exceed 36 hours unless the plan includes information from a psychologist on the health, safety, or therapeutic reasons for a longer restriction.
 - b. Include opportunities for the participant to reduce the length of time of a restriction.
 - c. Not include restrictions from employment unless they are due to health and safety concerns.

Participant/Guardian Verification

1. The participant, or guardian if applicable, shall read the narrative on the page and answer the yes or no questions listed. This section verifies:
 - a. The participant and/or guardian have been an active part of the plan development and acknowledge the responsibilities as a waiver participant.
 - b. The restrictions in the rights and restoration plan have been explained, along with his/her responsibilities.
 - c. The participant and/or guardian agrees or disagrees with the rights restrictions and restoration plan. Include his/her comments if there is a disagreement.
 - d. The participant and/or guardian have reviewed my choices in providers and waiver services available. Also, he/she knows that he/she has a choice between home and community based services and the Wyoming Life Resource Center.
 - e. The participant and/or guardian have been informed of his/her right to a Fair Hearing.
2. The participant, or guardian if applicable, and the case manager shall address the conflict of interest questions on the page, if the following conflict of interest exists:
 - a. The participant has chosen a self-employed case manager who also provides other services on the participant's plan of care, or
 - b. The participant has chosen a case manager employed by an organization that is also providing other services on the participant's plan of care.
3. If the conflict applies to the participant, then the case manager must work with the team to provide specific information to address the conflict of interest. Questions to address include:
 - a. How will the case manager assure the development of the plan of care is in the best interest of the participant? *Examples:*
 - i. "My case manager meets with me and my guardian to discuss ideas for the plan and seek my input at the team meeting and during home visits. My case manager makes sure all providers and my guardian are aware of the potential conflict of interest and the plan of care is developed as a team with input from everyone, including me and my guardian. If I, my guardian, or any other team member believes the case manager is not developing the plan of care in my best interest, then a team meeting is scheduled and the team discusses the concerns."
 - ii. "My case manager has listened to me when I discussed my needs and personal goals and has helped me to plan services and choose providers that will meet my needs. My case manager has ensured that my services are met best by a variety of providers."
 - b. How will the case manager assure monitoring of the implementation of the plan of care is in the best interest of the participant? *Examples:*
 - i. "My Case Manager monitors provider's documentation and incident reports. During Home visits, my case manager asks me about my services and if I have any concerns she should follow up on. She also told me to talk to ____ if I have concerns with my case management or respite services and how to file a grievance with her if I need to."
 - ii. "My case manager asks my mom to look at the units provided by all providers on my plan. If my mom has questions, the case manager will work with me and ____ to resolve the concerns."
 - c. How will the case manager assure choice of providers? *Examples:*
 - i. "My Case Manager explains that I have the right to choose among different providers. She assists, at my request, in contacting other providers. She reviews the provider list with me at least twice a year or when I have a concern, complaint, desire or need to change providers."
 - ii. "My case manager has helped me contact the Area Resource Specialist, and I know I can contact that person if I have questions or concerns."

Team Signatures and Information

1. All team members shall read the narrative on the page. After the plan is fully developed, and if they agree, they shall sign the plan of care. The plan is subject to approval by the Division. If changes are made in the approval process, the case manager must notify all team members.
2. If a team member's signature is unable to be obtained due to an extraordinary situation, then the case manager shall work with the waiver specialist on a timeline for submitting the signature or explaining why a signature cannot be obtained. Absent signatures result in the plan being "incomplete", and if absent signatures become a pattern, it shall be considered a certification issue.
3. Team member contact information shall be completed.
4. The plan shall be distributed to team members, after the plan of care is approved by the Division. Services shall not be provided until the pre-approval form has been signed by the Division.
5. Providers are responsible for notifying the case manager and the Division's Survey Certification Staff if a phone number, address, etc. change during the year.
6. Only team members, who provide direct services, should receive the plan of care. Psychological evaluation and other assessments should not be distributed.

SUPERVISION LEVELS

Supervision Levels

1. Residential Habilitation and Day Habilitation have tiered supervision levels and rates. There is a new service called Supported Living. There is NO longer the ability to use a 1:4 ratio when providing intermittent residential services unless a staff is on site 24 hours a day. See **"Supported Living Service Form"** and **"Personal Care Service Form"** in the **IPC Instructions** to accurately choose the services that are the best fit for the participant.
2. For services that have tiered rates based on supervision levels, the participant's ICAP Service Score is a starting point to determine the appropriate tiered rate. The ICAP Service Score does not guarantee a supervision level. It is important for a participant's habilitation providers and team to discuss the supports needed and compare those with the **"Supervision Level Descriptions"** to determine the appropriate supervision level for the service.
3. Descriptions of the tiered supervision levels are in Figure A-1. This table describes the level of supervision expected for each expected staffing ratio.
 - a. As described in Figure A-1, it is expected that a participant will receive some one-on-one supervision and assistance, regardless of the supervision setting.
 - b. A detailed description of supervision is required on **"My Services and Supervision Profile"** page.
4. If the participant has moved into a less restrictive living arrangement, such as moving from a group home to an apartment, the IBA will be re-calibrated to reflect a less intensive level of support.
5. If a higher supervision ratio was approved by the Division on the last plan, the same supervision level will be approved on the new plan as long as the plan of care continues to support that level of supervision. The case manager does NOT need to submit a new request.
6. If the participant requires a higher supervision level than in the previous plan, a **"Supervision Level and/or Intervention Request"** form must be submitted and the plan of care information must support the supervision level requested.
 - a. Instructions for the form can be found in the **"Supplemental Forms"** section of this document.
 - b. If the request for addition supervision exceeds the IBA, the Extraordinary Care Committee process will be followed. **Supervision level is subject to approval by the Division.**

ICAP Service Score Range	Figure A-1 SUPERVISION LEVEL DESCRIPTION (ICAP Service Score is a starting point to determine the appropriate supervision level)	Expected Staffing Ratio
1-22	<p>Intensive Supervision – Highly intense levels of support and supervision for an individual who has (1) Critical medical needs where 1:1 support is essential for sustaining health and well-being; or (2) Total and frequent personal care needs; or (3) Severe and persistent behaviors needing intensive, ongoing supervision and intervention. This level of support is provided in all circumstances during waking hours and requires one staff dedicated to that person at all times.</p> <p>Staffing Expectation - The expectation for this level is that a Direct Care Worker will supervise the participant during all waking hours while in service (and available on an as-needed basis during sleeping hours). This level should not be used for a participant that requires <i>periodic</i> one-on-one supervision.</p>	1:1
23-49	<p>High Supervision – Continuous support and supervision for an individual who requires close supervision, frequent verbal prompting or guidance, physical assistance for specific activities (i.e. eating, dressing, or bathing, or community outings), periodic 1:1 supervision and support, and/or continuous supervision because of severe and persistent behaviors where some physical intervention may be needed at times. Staff is present in the same room or within a safe proximity at all times.</p> <p>Staffing Expectation – The expectation for this level is that there will be, on average, one Direct Care Worker present and supervising no more than two participants during all waking hours in the habilitation service. This level assumes that the direct care worker will be available to provide specific, periodic one-on-one supervision to the participant during the day (and on an as-needed basis during sleeping hours, if applicable).</p>	1:2
50-64	<p>Medium Supervision – Consistent support and supervision for an individual who may be independent in some personal care skills, but may require some physical assistance or supervision with other activities of daily living, and direct, consistent supervision while in certain habilitation and community activities. The participant may have indirect supervision with provider available in another room or available by phone for brief periods during sedentary activities. The participant is able to accomplish most ADLs through verbal assistance or by utilizing checklists, and respond to verbal redirection for behavioral concerns. Individual will receive some 1:1 support.</p> <p>Staffing Expectation – The expectation for this level is that there will be, on average, one Direct Care Worker present and supervising no more than three participants during all waking hours in the habilitation service. This level assumes that the direct care worker will be available to provide sufficient periodic one-on-one supervision to the participant during the day (and on an as-needed basis during sleeping hours, if applicable).</p>	1:3
65 or above	<p>Low Supervision - Periodic support and supervision for an individual who is able to manage most activities of daily living independently, but may need periodic verbal prompting, monitoring, support, assistance, or supervision. The Individual may have some periods of unsupervised time at home or in the community. Individual will receive limited 1:1 support.</p> <p>Staffing Expectation – The expectation for this level is that there will be, on average, one Direct Care Worker present and supervising no more than four participants during all waking hours in the habilitation service. The Service Provider shall assist the participant, who lives in a group home or semi-independently, as outlined in the plan of care. This level assumes that the Service Provider will be available on site 24 hours per day to provide sufficient periodic one-on-one support and monitoring to the participant as needed.</p>	1:4

Figure A-2: Guidelines for Adjustments to Supervision Level and/or Intervention Units

Behavior	<p>A participant may need additional supervision/intervention for community outings due to aggression, elopement, inappropriate/illegal conduct, pedophilia, court-ordered supervision. If the person has a history of these behaviors, there should be a Positive Behavior Support Plan in the Plan of Care that addresses the need for extra staff or intervention hours to implement the support, which prevents or minimizes the likelihood of the above-mentioned behaviors occurring. The supervision or intervention is not intended for purposes of watching the person should the behavior occur, but for the purpose of teaching appropriate behaviors and keeping the participant safe.</p> <p>A participant may need 1:1 or 2:1 supervision during predictable episodic behaviors that happen occasionally or somewhat regularly. To the extent these episodes are predictable; they should be addressed in the Plan of Care.</p>
Health	<p>A participant may need additional supervision due to increased health needs. If a participant usually functions well with 1:2 staffing ratio or in a less intensive setting during healthy times, but needs 1:1 due to increased health needs, then this need should be described in the Plan of Care. If the request is due to a temporary change in a person's physical well being due to illness or accident, the justification should include the projected timeline and prognosis for recovery/remediation from the illness or accident and the specific support that will be implemented during this time. The authorization of additional staff or intervention should be time limited and monitored to determine the ongoing need.</p>
Safety	<p>Staff supervision/intervention for community outings, activities in the residential or day setting may be necessary due to mobility issues that necessitate 1:1 staffing. The frequency and need should be specified in the IPC and should specify the role of additional staff intervention.</p>
Medical	<p>Surgery/injury/rehabilitation time – temporary 1:1 staffing when person is in recovery (Intervention request would come in as a modification). Need may be due to a temporary change in a person's physical well being due to a medical condition – in these instances, justification should specify the health need being addressed and the specific interventions to be provided. The authorization should be time limited and monitored to determine the ongoing need.</p>
Personal Care	<p>An individual receiving a staffing level of 1:3 or 1:4, may need additional staff intervention periodically during the day for intensive mealtime, bathing, personal care, or pericare that is in addition to the regular 1:1 supports included in the Plan of Care. If additional 1:1 intervention is required, then the Plan of Care should specifically identify the activities of daily living that require 1:1 intervention to meet the specified personal care need.</p>

SUPPLEMENTAL FORMS

For Services and Eligibility

Objectives -Habilitation Services

1. In the “**About Me**” section, the participant has identified long-term goals for the future. A goal is a brief, clear statement of an outcome to be reached within a timeframe such as 3-5 years. A goal is a broad, general, tangible, and descriptive statement. It does not say how to do something, but rather what the results will look like.
2. In comparison, an objective is a specific, measurable, attainable, relevant, time specific and trackable condition or skill that must be attained in order to accomplish a particular goal. Objectives define the actions, which must be taken within a year to reach the goal. A goal is where you want to be and objectives are the steps taken to reach the goal.
3. Habilitation services assist with the acquisition, retention, or improvement in skills related to living in the community. Therefore, habilitation services require objectives. Training on the objective must be a part of each billable time period of habilitation service provided. Services requiring objectives include:
 - a. Residential Habilitation
 - b. Supported Living (separate service form)
 - c. Day Habilitation
 - d. Group Supported Employment (separate service form)
 - e. Community Integrated Employment (separate service form)
 - f. Special Family Habilitation Home
 - g. Residential Habilitation Training
4. Objectives shall be derived from:
 - a. Discussions about the participant’s long-term goals at IPC team meetings
 - b. Information on long-term goals and areas of interest in the “**About Me**” section
 - c. Health and safety concerns that are barriers in achieving the participant’s goals
 - d. Participant, family, or team member ideas about how the participant may become more independent or make progress towards larger life goals
 - e. Reviewing progress or status on past objectives, and identifying the next achievable objective to reach the participant’s goal.
5. The provider of the service on the objective form is responsible for writing the objective and developing the schedule for the service. The Case Manager or other team members may assist the provider in developing the objective and schedule, if needed or requested.
6. All sections on the objective page shall be completed, including:
 - a. **Correct code**
 - b. **Start date** (*corresponding with plan date*)
 - c. **Review date** (*monthly, quarterly, or semi-annually*)
 - d. **Number of units** (*If the team requests less than 350 days of Residential Habilitation and/or less than 230 days for day services, a statement is required why services are not needed throughout the year.*)
 - e. **Provider responsible** (*If more than one provider is listed, then a person must be identified who will monitor for progress, consistency and continuity of services.*)

7. Objective pages, including the meaningful, measurable, and methodology parts should contain the **SMART** components: **S**-specific, **M**-measureable, **A**-attainable, **R**-relevant, **T**-time specific & trackable.
 - a. **Specific:** State exactly what objective the participant will accomplish.
 - i. "My objective is" shall answer, "I will do what, where, how often, and for how long?"
 - ii. Objective shall not be too lengthy or contain too many items.
 - iii. It shall be written in first person language.
 - b. **Measurable:** Specify when the participant and team will know the objective has been achieved.
 - i. Answer "How will this objective indicate how I am doing" with criteria for evaluating performance and completion of each step or task.
 - ii. Specify the criteria or achievement level, which indicates overall success of the objective.
 - c. **Achievable:** Describe how achieving the objective is realistic with effort and commitment.
 - i. "How will the objective help me" shall address the Achievable and Relevant components.
 - ii. The response should describe how the objective will help the participant achieve something he/she cannot currently do successfully.
 - d. **Relevant:** Explain why the objective is significant to the participant in the "How will the objective help me" question.
 - i. Explain how the objective will be meaningful to the participant and his/her goals.
 - e. **Time-specific:** Specify when the objective shall be achieved.
 - i. Most target dates will be one year from the start date, but for participants who achieve objectives more quickly, the target dates shall be set as appropriate for the participant.
 - f. **Trackable:** Describe how the objective shall be tracked and how the data shall be used in the "Methodology".
 - i. Objectives shall be measured using a task analysis approach. The task analysis can be on the habilitation schedule or on a separate form.
 - ii. Task Analysis includes the objective, steps for accomplishing the objective, training strategies for teaching the steps, and measurement criteria for evaluating each step and measuring progress on the objective all together.
8. **"If this objective is being continued from the previous plan, indicate progress made"** should:
 - a. Briefly summarize last year's progress on objective in measurable terms.
 - b. Note areas of significant strength and/or weakness on the objective
9. **"Methodology"** shall contain specific action steps needed to accomplish the objective:
 - a. Describe training activities or steps the participant will practice. Specify strategies for providers to teach, demonstrate, and observe steps of the objective.
 - b. Steps or tasks shall be detailed according to the participant's level of ability and understanding.
 - c. Include the level of assistance providers will use to train, such as gestures, positive reinforcement, hand over hand, role-play, verbal prompt, pictures, etc.)
 - d. List the ways it can be practiced, environments in which it can be done, and parties involved, if it can vary.
 - e. Information from the "Trackable" requirement as explained previously.
10. **Documentation and evaluation requirements.** The objective and steps of the objective must be included in a task analysis on the schedule or on a separate form. The case manager shall receive monthly documentation from the provider(s), including progress on the objective, by the 10th business day of the next calendar month.
 - a. Case managers are responsible for assuring:
 - i. If more than one provider is listed, then a person must be identified who will monitor for progress, consistency and continuity of services.

- ii. If the objective page is used by more than one provider, there must be an easy identification to see which provider is responsible for the form and its implementation (important for auditing and billing review).
- iii. If objective has been the same for a year or more and the participant is not achieving success, then the following options will be given:
 - 1. Objective may be revised to try new methodologies, new strategies and activities, be more specific, or
 - 2. Objective may be changed completely, or
 - 3. Case manager is advised to either:
 - a. Add the objective or goal to the schedule to record on-going training in this area
 - b. Include this unachieved objective in the pertinent areas of the plan of care where supports and supervision are described.

Schedules

1. Schedules must accompany habilitation objectives, respite, personal care, and homemaker service forms.
2. Schedules shall be:
 - a. A personalized list of tasks or activities that describe a typical week for a participant.
 - b. Individualized and reflect the wants and desires of the Participant as listed in “**About Me**”.
 - c. Developed with each provider on the team to determine what the schedule should include.
3. A schedule shall include:
 - a. Name of Participant
 - b. Service Code or Description
 - c. Plan Date
 - d. Location of Service
 - e. Name of service being provided
 - f. Approximate number of hours in service (per day/week/month)
 - g. Details on training on specific objectives for habilitation services (if methodology for objective is on the schedule instead of a separate objective page)
 - h. Level or brief description of supervision needed as specified in the plan of care (staff ratios do not have to be included unless the person requires 1:1 or higher)
 - i. Personal care needs during the time of service, if applicable
 - j. Health and safety needs
 - k. Behavior plan components, as applicable: targeted and replacement behaviors, use of PRNs, restraints and restrictions. *(providers do not need to double track if this data is collected separately)*
 - l. Participant’s choice of activities
 - m. Community outings *(provider should fill in specific location when documenting on the schedule)*
 - n. Date *(month, date, year)*
 - o. Time in and time out for provision of services
 - i. Choose AM/PM or military time
 - ii. Staff needs to identify time consistently on the schedule and not switch between AM/PM and military time
 - iii. More than one box for “time in/time out” must be available, if the Participant leaves the service more than once a day for therapies, other waiver services, school, etc.
 - p. Place for each staff member of each provider to initial when tasks have been completed *(Initials must match full signature)*
 - q. Place for full signature for each staff member of each provider *(per physical page)*

- r. Notes/Comments section (*if completed, include date of comment*)
- 4. Social Security Numbers and Medicaid ID numbers on the schedule are discouraged. Due to HIPAA concerns, if schedules were taken into the community, the identification numbers would not be safe to have on the schedule.
- 5. The schedule verifies services were delivered for billing purposes. Therefore,
 - a. It must be developed with all of the above components, and
 - b. Filled out, initialed, and signed by staff accurately, or
 - c. The provider may have to pay back money for services if standards are not followed.
- 6. Providers must adhere to the documentation and reporting standards in rule and may develop individualized format. There are examples on the Division's website.
- 7. Each provider is responsible for developing, updating, and distributing the approved schedule for their service to all staff or team members who deliver the service, as well as giving a copy to the case manager.
 - a. If the provider needs assistance with developing the schedule, the case manager should assist the provider as needed.

Service Requirements

Listed alphabetically

Cognitive Retraining Service Form (ABI only)

1. Provider must provide all information on the Service form.
2. There is no schedule required for this Service but one could be developed.
3. The professional must document what occurred during each session

Employment Services Form

1. The form is required only if the participant is requesting either group supported employment or individual community integrated employment services from the waiver.
2. Fill in the required information regarding the participant's name, mark the box for the appropriate service needed, and the provider's name and units allotted.
3. Fill out the employment objective portion of the page in accordance to the expectations in the "**Objectives**" section of the *IPC Instructions*. Objectives must identify the supports needed for the participant to keep his/her job or locate a job.
4. Waiver supported employment also requires a schedule, per *IPC Instructions*.

Environmental Modifications

1. Refer to Chapter 44 of Medicaid Rules for specific details regarding Environmental Modifications.
2. Environmental modifications requests shall meet at least two of the following criteria for approval by the Division:
 - a. Be functionally necessary, and
 - i. Contribute to a person's ability to remain in or return to his or her home and out of an ICF/MR setting, or
 - ii. Be necessary to ensure the person's health, welfare, and safety.
4. If the environmental modification meets the criteria, then the case manager will submit the request to the Division, including:
 - a. A description of the environmental concern or need.
 - b. How the environmental concern is related to the participant's diagnosed disability
 - c. How addressing the environmental concern will:

- i. Contribute to the participant's ability to remain in or return to his or her home.
 - ii. Increase the participant's independence.
 - iii. Address the participant's accessibility concerns.
 - iv. Address health and safety needs of the participant.
 - 5. After the request is submitted, the Division may:
 - a. Schedule an on-site assessment of the environmental concern including an evaluation of functional necessity with appropriate professionals under contract with the Division, or
 - b. Instruct the case manager to proceed to (6).
 - c. Deny the request
 - 6. If the request is approved, then the case manager shall submit the pre-approval section and service page of the individual plan of care to the Division, including:
 - a. Photos or drawings
 - b. Two quotes completed by certified environmental modification providers, which shall include:
 - i. A detailed description of the work to be completed, including drawings or pictures when appropriate.
 - ii. Estimate of material and labor needed to complete the job, including costs of clean up.
 - iii. Estimate for building permit, if needed.
 - iv. Estimated timeline for completing the job.
 - v. Name, address, and telephone number of the provider.
1. *If two quotes cannot be obtained, an explanation shall be attached as to why only one quote was submitted.*

Habilitation Services

1. All habilitation services require an objective service form and a schedule. Use the "Habilitation Service Form" for Residential Habilitation, Day Habilitation, Residential Habilitation Training, or Special Family Habilitation Home. Use other service forms for Supported Living or Employment Services. Refer to the "**Objectives**" and "**Schedules**" sections of the IPC instructions for details on completing the necessary requirements.

Homemaker Service Form (Children's DD waiver only)

1. A service form should be completed, explaining the general allocation of units and a general description of Services.
2. A schedule must accompany the service form.

Intervention Units

1. Intervention units can be used for situations where a participant's standard supervision level may not provide sufficient staffing for specific activities or events included in the IPC, but the supervision level is not needed at all times. Eligible situations for intervention are on Figure A-2.
 - a. The intervention option shall be used to request additional staff, when needed, to provide intensive 1:1 support for the participant, because the assigned setting is not adequate to meet specified health and safety needs.
2. It is expected that a participant will receive 1:1 support at times specified in the IPC for assistance with ADLs and for objective training, regardless of the supervision level.
3. If intervention units were approved by the Division on the last plan, those units will be approved on the new plan as long as the plan of care continues to support that level of supervision. The case manager does NOT need to submit a new "**Supervision Level and/or Intervention Request**".
4. If the participant requires additional intervention units than were approved on the previous plan, then a "**Supervision Level and/or Intervention Request**" form must be submitted and the plan of

care information must support the supervision level requested.

- a. Instructions can be found on page 18 of this document.
- b. If the request for additional intervention exceeds the IBA, the Extraordinary Care Committee process will be followed. **Intervention requests are subject to approval by the Division.**
5. In the **“My Services and Supervision Profile”** section of the IPC, intervention utilization must be explained. Specify the service (residential and/or day habilitation) where intervention will be used, how the additional staff person for intervention is accessed, and for what the intervention will be utilized.
6. A schedule must accompany all Intervention services. Schedules shall be:
 - a. A personalized list of daily living activities, behaviors or tasks that need exclusive staff support and supervision.
 - b. Reflect the specific areas of concern in the areas of health and safety.
 - c. Developed by the provider who will do the intervention with the participant.
7. A schedule shall include:
 - a. Name of Participant
 - b. Service Code and Service Description
 - c. Plan Date
 - d. Location of Service
 - e. Type of Intervention being provided
 - f. Approximate number of intervention hours (per day, week, or month)
 - g. Details for staff on how to intervene with the participant to address the specific behavior, medical need, personal care, or other usage.
 - h. A description of the level of support needed for specific activities, such as total assistance, hand over hand, etc.
 - i. Personal care needs during the time of service, if applicable
 - j. Health and safety needs
 - k. Behavior plan components, if applicable

Occupational Therapy, Physical Therapy, Speech Therapy, Dietician Service Forms

1. Occupational Therapy, Physical Therapy, and Speech Therapy have an individual rate and a group rate. The participant may receive either individual, group, or both, and the physician’s order must reflect which service is appropriate for the participant.
2. There must be an assessment prior to therapy services, with a date included.
 - a. The waiver specialist may request an updated assessment.
3. Recommendations from therapist can be on this form or attached.
4. Therapist should explain why the needed service is not billable to Medicaid.
5. Review date must be at least every 6 months.
6. A description of the expected outcome of therapy and how outcomes will be measured must be clearly stated.
7. If the therapist is not filling out the form, he/she must give the necessary information to the case manager.
8. Therapist signature is only needed if the therapist completes this form.
 - a. If there is a separate recommendation letter with a signature and date, write “see attached recommendation”.
9. A Physician’s order must accompany all requests for therapy, except Dietician.

Personal Care Service Form

1. A service form should be completed, explaining the general allocation of units, provider(s) responsible, and a general description of services. Units shall be based on individual need with a

maximum of 7280 units of personal care in a plan year, unless more are approved by the Division due to extraordinary circumstances.

2. Personal Care includes tasks that need to be accomplished for a participant through hands-on assistance (actually performing a task for the person) or cuing/prompting the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis and do not have to have a teaching or training component.
3. Personal care can include Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
 - a. **ADLs** include bathing, dressing, toileting, transferring, positioning, maintaining continence, personal hygiene tasks, eating, etc.
 - b. **IADLs** include more complex life activities, such as light housework, laundry, meal preparation, exclusive of the cost of the meal, transportation, grocery shopping, using the telephone, medication and money management.
4. If the participant lives with a family member or caregiver, the Circle of Support is optional.
5. A **Circle of Support** must be developed for all participants who live independently with monitoring or support and receive personal care services. On the personal care service page include the following helpful information as determined by the team to be important contact information for the participant:
 - a. **Situations:** list items such as housing issues, plumbing problems, uninvited visitors, witness to illegal activity, providers not showing up, taxi or city transit needs, medication problems, food shortage, mental health, social gatherings (bowling, church, bingo, etc), medical appointment help, emergency assistance (police, fire, ambulance), poison control, etc. *Each person has a tendency to have different support needs, fears, or people they need to be able to access in order to live independently. Address the main situations pertinent to the participant.*
 - b. **Contact person:** List the specific person's name and title who they can contact. These people may family members, friends, neighbors, taxi, bus, advocate, providers, landlord, natural supports, community members or agencies, or local emergency agencies.
 - c. **Phone number:** List the phone number for the contact person and remember to update the number if they change.
2. The contact persons should know they are the person's contact list, unless they are a general community business or emergency assistance. The participant needs to be trained on using the circle of support and it shall be posted in a convenient and visible area in the home.
3. If Personal Care is needed at the same time as other services, such as SFHH, Respite, or Therapy Services, then the need for more than one service provider must be clearly identified on both service forms. *The Division shall review the arrangement before a pre-approval is signed.*
4. A schedule must accompany the Service form.

Respite Service Form

1. Respite is intended to give short-term relief for the primary caregiver and is not intended to be used when the primary caregiver is at work.
2. On the Adult DD and ABI Waivers, the Respite Cap is 3,000 units for the plan year. On the Children's waiver, the cap is 7280. Unit requests exceeding the cap shall be requested through ECC.
3. Respite cannot be used during regular school hours unless there is a documented reason why the child is not in school.
4. A Service form should be completed, explaining the general allocation of units and a general description of Services.

5. If Respite Care is needed at the same time as other services such as: SFHH or Therapy Services, the need for more than one service provider must be clearly identified on both service forms. The Division shall review the arrangement before a pre-approval is signed.
5. A schedule must accompany the service form.
6. This schedule must be descriptive of the services provided.

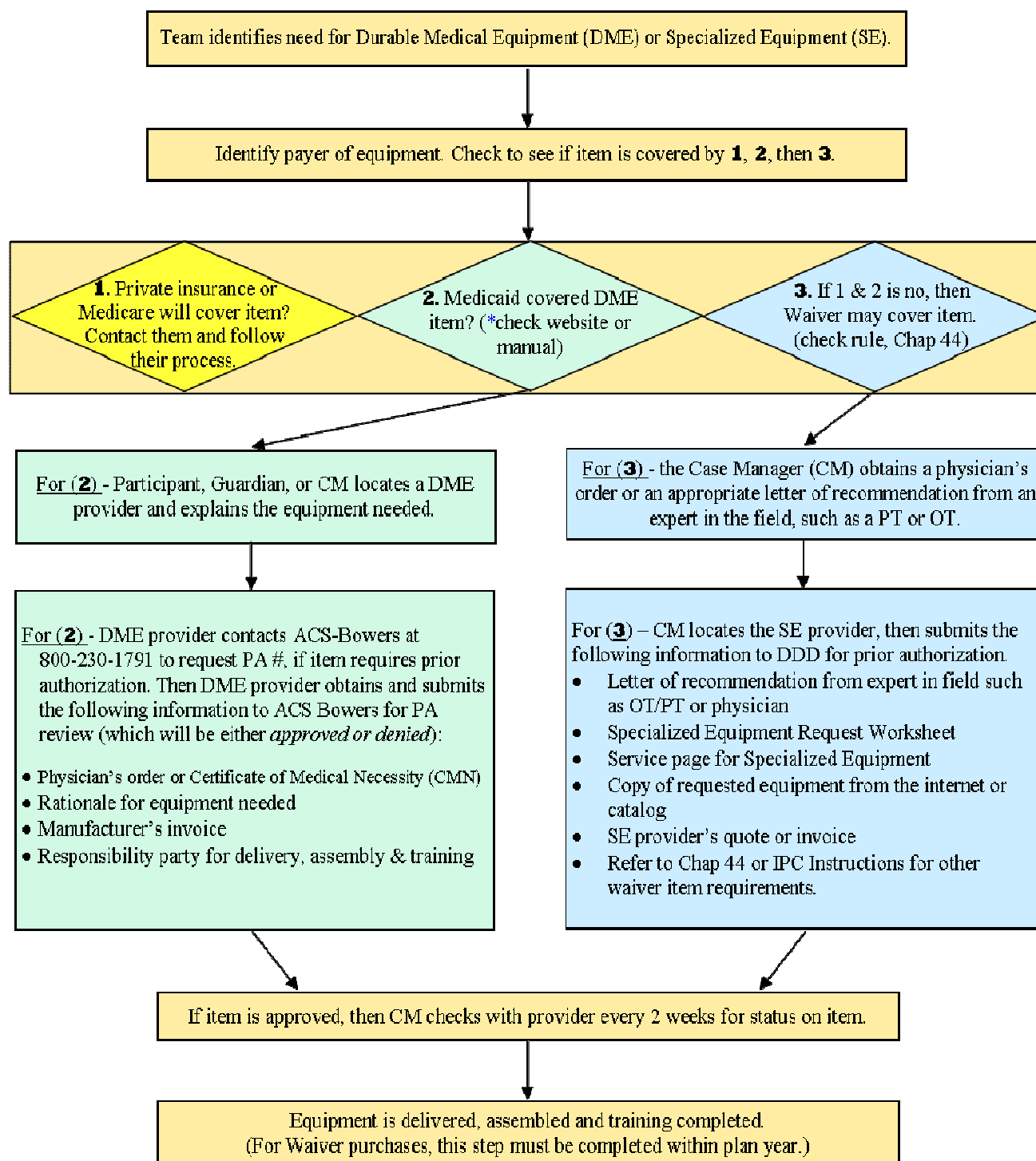
Skilled Nursing Services

1. A **“Physician’s Order for Skilled Nursing Services”** form must be completed, including preventative and rehabilitative procedures.
2. The form requires a physician’s signature, not a stamp. The physician should be fully involved in the participant’s medical treatment plan. The physician shall carefully review the skilled nursing services needed for the participant before signing the order. A blank form cannot be signed by the physician. No signature stamps will be accepted.
3. The services on the physician’s order must be reflected in the documentation of services delivered.

Specialized Equipment

2. Refer to Chapter 44 of Medicaid Rules for specific details regarding Specialized Equipment, including identifications of items not allowable.
3. Requests for specialized equipment should be discussed at the annual meeting or the six-month review, unless there are significant health and safety concerns.
4. The waivers will not purchase any equipment that would be authorized under the Medicaid state plan or under EPSDT.
5. Refer to the **Flowchart for DME or Specialized Equipment** Requests included in these instructions. This is a process for checking if the equipment is a Medicaid covered DME item and, if not, the process for requesting equipment through the waiver.
6. If the item(s) are not covered by Medicaid, continue on the right hand side of the Flowchart.
7. A Specialized Equipment Request Worksheet is available on the website to assist teams in determining whether an item will meet the standards in Chapter 44 of Medicaid rules on covered items.
8. A detailed letter of recommendation from an expert in the field, such as PT/OT or physician.
9. Use the checklist for requesting specialized equipment on the DDD website.
 - a. If the therapist or physician has not completed the checklist, the case manager should do so.
 - b. If the team is requesting multiple items, a checklist should be prepared for each grouping of equipment.
10. Complete the service page, answering all questions. Also submit to the Division:
 - a. Copies of requested equipment from the internet or catalog
 - b. The specialized equipment provider’s quote/invoice details:
 - i. The quote/invoice shall be itemized, separating markup, shipping, and other costs.
 - ii. The quote/invoice may include a detailed description of the need and costs for expert assembly of the equipment in addition to 20% markup.
 - iii. The quote/invoice may include a detailed description of the need and cost for training on the specialized equipment in addition to the 20% markup.
11. The Division may schedule a review of the specialized equipment quote, including an evaluation of functional necessity, with appropriate professionals under contract with the Division.

FLOWCHART FOR DME OR SPECIALIZED EQUIPMENT



* <http://wyequalitycare.acs-inc.com/manuals/dme/>

Subsequent Assessments (No service form)

1. If the assessment has not yet been completed before the Plan of Care is submitted, then the case manager must submit documentation for prior authorization stating:
 - a. Type and purpose of assessment
 - b. Professional completing the assessment, including credentials
 - c. The cost and proposed completion date.
2. Any subsequent assessments new to the participant or unrelated to a service on the pre-approval page shall have prior authorization from the Division. If so, then the case manager must submit a request for the assessment with all of the components listed above.
3. Once the assessment is completed, a copy must be sent to the Division.
4. If the psychological assessment was completed prior to the Plan of Care, the case manager must submit a copy of the assessment and a copy of the invoice.

Supervision Level and/or Intervention Request Form

A supervision request form is not required if the team believe a less intense supervision level will meet the participant's needs and will encourage greater independence.

1. Supervision levels with tiered rates apply to Residential Habilitation and Day Habilitation. Intervention units can be added to these services only.
2. The form shall be used, if one of the following applies:
 - a. The participant has not received Residential or Day Habilitation before and the Supervision level corresponding to his/her ICAP Service Score is not indicative of the supervision needed.
 - b. The participant needs more supervision than provided on last year's approved plan due to health and safety reasons.
 - c. A new ICAP Service Score reflects a different supervision level, which the team states is the actual supervision level needed for the participant's health and safety. NOTE: A newer ICAP service score does not automatically assure a different supervision level.
 - d. The team is requesting more intervention to meet the participant's health and safety needs.
3. When using form to justify a request for a higher supervision level, the habilitation provider shall:
 - a. Identify the current ICAP Service Score and the approved supervision level in last year's plan.
 - b. Indicate the supervision level which would be a more appropriate staffing ratio.
 - c. Provide an explanation for the different supervision level being requested and how it will meet the participant's health and safety needs. Then indicate:
 - i. The number of participants in the home or day habilitation setting
 - ii. The number of staff routinely assigned to that setting
 - iii. If additional staff would be available for parts of the day, then describe the type of activity, the number of staff assigned, and the length of time they are present.

Supervision level is subject to approval by the Division.
4. For Intervention, describe how the intervention staff is accessed and his/her intervention duties. (Intervention units cannot be supplied by someone routinely assigned to the unit who has regular supervision duties with other participants at the same time.)
 - a. Describe how the additional supervision will be documented by the provider, which verifies that the additional supervision is being provided to this individual.
5. When using the form to justify the use of Intervention units, the habilitation provider shall:
 - a. Provide the answers to the questions in #3c above.
 - b. Indicate the number of intervention units being requested.
 - c. Describe the behavioral, health, safety, medical, and/or personal care issues that would require a more intense supervision level. *See Figure A-2 for additional guidance.*

- d. If the activity is episodic and not schedule driven, explain the types of episodes and the frequency of such behaviors or needs.
- e. Detail intervention utilization by staff. Specify the behaviors or needs requiring intervention.
- 6. This form shall be submitted to the Division for review and approval with the annual plan of care.
 - a. This form may also be submitted as part of a modification request to the plan of care. **Intervention units are subject to approval by the Division.**
 - b. If approved, then the plan of care will need:
 - i. The supervision level on the “**My Services and Supervision Profile**” section to reflect the same requested supervision level.
 - ii. If it is a modification to a current plan, then the “**My Services and Supervision Profile**” section may be changed after the request is approved.
 - iii. For approved intervention, an intervention schedule will be needed to reflect the higher supervision/intervention.
 - iv. The habilitation schedules must reflect any 1:1 or 2:1 supervision needs.
 - c. If the justification request is denied, the Division will send a denial in writing, and
 - i. The supervision levels on the pertinent sections of the plan will need to be changed to the approved supervision level.
 - d. If the Plan of Care cost exceeds the Individual Budget Amount (IBA), submit a request to the Extraordinary Care Committee (ECC).

Supported Living Services Form

1. Supported Living services are services to assist participants to live in their own home, family home, or rental unit. These individuals do not require ongoing 24-hour supervision but do require a range of community-based support to maintain their independence. They require individually tailored supports to assist with the acquisition, retention, or improvement in skills related to living successfully in the community.
2. Supported living services shall be based upon need. These services can include: assisting with common daily living activities; performing routine household activities to maintain a clean and safe home; assistance with health issues, medications, and medical services; teaching the use of the community’s transportation system; teaching the use of police, fire and emergency assistance; managing personal financial affairs; building and maintaining interpersonal relationships; participating in community life; and 24-hour emergency assistance. This service includes personal care, therefore personal care services cannot be added as a separate service on the plan of care.
3. The plan of care must identify either the daily unit or the 15-minute unit based on the participant's need. The daily unit requires a minimum of 4 hours a day of services and can be reimbursed for up to three (3) participants. The maximum of 15-minute units will be 5400 units in a plan year for the group rate and 3900 units for the individual rate.
4. On the service and objective form, mark the correct service code and description.
5. List the units needed and the provider of the service.
6. Develop an objective and methodology according to the standards in the “Objective” section of these instructions.
7. If the participant lives with a family member or caregiver, the Circle of Support is optional.
8. A **Circle of Support** must be developed for all participants who live independently with monitoring or support and receive supported living services.
 - a. On the supported living service form or personal care service form, include the following helpful information as determined by the team to be important contact information for the participant:

- i. **Situations:** List items such as housing issues, plumbing problems, uninvited visitors, witness to illegal activity, providers not showing up, taxi or city transit needs, medication problems, food shortage, mental health, social gatherings (bowling, church, bingo, etc), medical appointment help, emergency assistance (police, fire, ambulance), poison control, etc.
 - 1. NOTE: *Each person has a tendency to have different support needs, fears, or people they need to be able to access in order to live independently. Address the main situations pertinent to the participant.*
 - ii. **Contact person:** List the specific person's name and title who they can contact. These people may be family members, neighbors, providers, the landlord, a natural support, community members or agencies, or local emergency agencies.
 - iii. **Phone number:** List the phone number for the contact person and remember to update the number if they change.
9. The contact persons should know they are on the person's contact list, unless they are a general community business or emergency assistance. The participant needs to be trained on using the circle of support and it shall be posted in a convenient and visible area in the home.
10. The objective and steps of the objective must be included in the schedule or on a task analysis form. Case managers should receive monthly documentation from the provider, including progress on the objective, by the 10th business day of the next calendar month.

Other Form Requirements

Listed alphabetically

Guardianship Papers

1. Whenever there is a court appointed guardian, guardianship papers must be submitted with plan.
2. For a child under 18, his/her parents are the legal guardian unless an alternate person is appointed by a court.
3. When a child turns 18 years of age, he/she is legally an adult and is responsible for signing all Plan of Care documents unless there is a court order changing that status.
 - a. The Division cannot accept guardianship papers that state "minor child", if the participant is 18 or older, unless it meets the following criteria:
 - i. "A guardianship, initiated while the ward is a minor, does not lapse at the age of majority under Wyo. Stat. Ann. 3-3-1101, if it is based on incompetency as defined in Wyo. Stat. Ann. 3-1-101(a)(ix) or (xii)."
 - b. The case manager is responsible for having the participant sign the forms until the guardianship can be corrected.
4. If there is a limited guardianship, assure that the dates are current.
5. For a child, if guardianship papers not available, an explanation must be submitted.

Inventory for Client and Agency Planning (ICAP)

1. The three (3) page ICAP summary must be submitted with the plan.
2. The ICAP is an assessment tool that should be reviewed before or during the Plan of Care meeting.
3. If the ICAP lists maladaptive behaviors as moderate or above, a positive behavior support plan must be written. If these behaviors are no longer a problem, then the case manager will need to explain the reasons for not addressing the behaviors in writing when submitting the plan of care.
4. After the initial ICAP, the assessment is completed every five years for adults and children, unless requested otherwise by the waiver specialist.
5. If the ICAP will expire before the next plan year, the case manager should submit an ICAP checklist and supporting documentation.

Level of Care Form: LT-MR-104 and LT-ABI-105 Revised form 2/08

1. The LT-MR-104 form is used for level of care determination for Adult DD or Children's DD Waiver eligibility. The LT-ABI-105 form is used for the level of care determination for ABI waiver eligibility.
2. Check the box in the top right hand corner to specify the waiver applicable to the participant.
3. The participant's physical address must be complete, including city and zip code.
4. The participant's Medicaid ID number must be listed.
5. The current diagnosis for the participant must be completed. For individuals with a MR diagnosis, the level of MR must be included.
6. The screening date is the date the form is completed. This must be less than 365 days from the screening date on the last form.
7. The plan of Care date is the date the upcoming plan will start.
8. The pending Plan of Care date, when applicable, is for new applicants who have not had a plan of care submitted before. If it does not apply to the participant, mark N/A.
9. The ICF/MR admit date should be marked N/A. *(Only the Wyoming State Training School would mark an admit date here).*
10. The placement is the case manager organization.
11. The county of the participant's physical address must be identified.
12. The individual must meet the ICF/MR Level of Care by having the following combinations of **yes's**:
 - a. An Individual is approved for ICF/MR Level of Care by the case manager marking the necessary number of "Yes's" to any of the following combinations of Columns A-C and Row D:

<u>Column A</u>	+ <u>Column C</u>	+ Row D	<u>Active Treatment</u>	= Approved ICF-MR
2-Yes		1-Yes	1-Yes	
or				
<u>Column B</u>	+ <u>Column C</u>	+ Row D	<u>Active Treatment</u>	+ Approved ICF-MR
2-Yes		1-Yes	1-Yes	
or				
<u>Column C</u>	+ Row D	<u>Active Treatment</u>	= Approved ICF-MR	
3-Yes		1-Yes		
13. To be eligible for the waiver:
 - a. Mark "yes", the individual meets ICF/MR Eligibility Criteria.
 - b. Mark "yes", it is anticipated the individual will need this level of service consecutively for 30 days or more
 - c. Mark "yes", the individual meets the definition of developmental disabilities or acquired brain injury.
14. The case manager must print his/her name, sign the form and provide a telephone number for DFS.
15. A new form must be submitted to the Division and DFS annually and for every change of residence, case manager organization, or Waiver. Annual submission required even if there is no change.
16. **For an initial plan**, DFS should receive this form along with a copy of the funding letter as soon as possible so financial eligibility can be determined and DFS can correctly code the participant on the correct Waiver. DFS will review the case for financial eligibility and send a pending letter to the Participant and case manager.

Pre-Approval Form *Revised form 3/08*

1. All Waiver Services must be prior-authorized by the Division. The Pre-approval form must be completed with the waiver services requested for the plan year. Only certified providers can be listed on the form.
2. In completing the Pre-approval form, the case manager shall:
 - a. Complete all spaces indicated on the form.
 - b. Use NPI numbers for all providers who have them.
 - c. Use the current Individualized Budgeted Amount (IBA). If not known, call the waiver specialist for the IBA.
 - d. Assure that all information is accurate and complete.
 - e. Do not leave any item blank.
 - f. Calculate the units and rates and assure the amount is within the IBA.
 - g. Double check all money totals on the form.
 - h. Assure all signature lines are signed and dated.
3. For an Annual Plan of Care submission, write N/A in the Modification Effective Date space.
4. If a child will age out of the Children's DD Waiver during the plan year, the IBA and units must be calculated to reflect the correct number of days in service up to his/her 21st birthday.
 - a. When a child transitions onto the Adult Waiver on his/her 21st birthday, case management shall be billed to the Child's DD Waiver for the birth month, unless otherwise approved.
5. Any request for units over the approved limit must be submitted in writing with reasons given. Division will review and notify the case manager of the decision.
6. Assure service rates are correct for the appropriate waiver. Use appropriate modifiers for tiered supervision levels and correct modifiers for groups, when appropriate.

Psychological/Neuropsychological Evaluation

1. Reports must include diagnoses, and for the Adult and Children's DD Waivers, the full-scale IQ score.
2. If the Psychological evaluation will expire before the next plan year, the case manager should work with the waiver specialist and submit a modification to have a new psychological evaluation.
3. A Psychological/neuropsychological evaluation must be included with a Plan of Care.
4. Evaluations shall be done every 5 years, unless otherwise requested by the waiver specialist.
5. Recommendations from the Psychologist must be addressed in the Plan of Care.
6. A Licensed Psychologist must sign and date the evaluation.
7. If a Participant qualifies for Waiver Services because of a related condition,
 - a. The condition must be reflected in the psychological report, or
 - b. Additional medical documentation by a physician or medical specialist must be submitted.

Technical Checklist

1. Use the Technical Checklist to verify that all of the components of the plan of care being submitted to the Division are complete, with no parts overlooked or incomplete. Use Revision 4/09.
2. On the second page, check all services and supplemental forms submitted with the plan.
3. Submit the checklist in the front of the plan.
4. Submit the plan with all documents in the order of the Technical Checklist. Missing components of the plan will result in the plan being incomplete. Incomplete plans will not be reviewed by waiver specialists until all components and signatures are submitted.

MODIFICATIONS

Modifications to the Plan of Care

1. Modifications to end the plan of care shall be submitted when the participant moves out of state, passes away, or quits the waiver. Ending the plan of care shall occur within 45 days of the event. If participant or guardian is no longer available to sign, note it on Pre-approval form.
2. Modifications shall be submitted when there is a change in services, service rates, service units, providers, or plan start date.
3. An explanation for the need of a modification shall be submitted.
4. The transition process must be followed and the transition checklist submitted if the modification is a change in case manager, residential placement, or day services.
5. **REQUIRED:** The Pre-approval form must contain all service lines with the most current units from the plan, not just the service lines that are changing. For example, if day habilitation units have changed from 250 to 200 units, then the current service line listed should state 200 units.
 - a. *Best Practice:* Case managers should have an electronic copy of the pre-approval and all modifications made, so the units and services are accurately tracked throughout the year.
6. Indicate, by arrows (↑ or ↓), if the units are increasing, including new services, or decreasing, such as a service or provider being removed from plan.
7. The case manager must have accurate information from providers on units billed and services provided before completing the Pre-approval form.
8. Any service form, objective page, or schedule changing due to increased or decreased units must be included.
9. In addition to the Pre-approval form, any service forms, schedules, and the **“Team Signatures and Information”** page shall be included in the packet submitted.
 - a. Signatures must include all providers whose rates/units are being changed.
 - b. In extraordinary situations, work with the waiver specialist if signatures cannot be obtained from the necessary parties.
10. **“Modification Effective Date”** must be completed in the space provided on top of the Pre-approval form. The Division has seven (7) days to process a modification from the date that a complete and accurate packet is received.
 - a. If an exception is necessary, the request should be submitted in writing followed up by a phone call to the waiver specialist.

DEFINITIONS

Advocate

Person who exercises his/her right to be heard on matters important to him or her, or represents another person's plea or cause.

Antecedents

Actions or statements that take place before a targeted behavior occurs.

Baseline data

Performance-based information gathered before a program begins. It is used later to provide a comparison for assessing program impact.

Competency-based training

Training for a provider so he/she can demonstrate the knowledge, skills, and abilities necessary in working with the participant on specific plan of care items.

Conflict of Interest

Specific to the plan of care, a conflict of interest is a situation in which a case manager has competing or conflicting interests or loyalties. Examples include:

- A self-employed case manager also provides other services on that participant's plan of care.
- An organization employs a participant's case manager, and also provides other services on the participant's plan of care.

Cue

Any signal, statement, gesture, or action identified, which should be followed with a specific action.

Data

Multiple facts used as a basis for inference, testing, models, etc.

Dignity

Bearing, conduct, or speech indicative of respect, appreciation of an occasion or situation and showing a person they are capable, worthy and valuable.

Emerging behaviors

Actions or statements that arise from a participant before targeted behaviors usually occur.

Enclaves

Enclaves typically consist of a group of individuals with disabilities working together under the supervision of an agency employee in a community business or industry. There is a contractual relationship between the business and the agency, and the agency pays the workers with disabilities at or above minimum wage.

Functional behavioral analysis

Information gathered relating to the what, when, where, who and why of the targeted behaviors. Information is gathered through direct observation of the participant's targeted behaviors as they emerge and decline, interviews with people familiar with the participant who can give details on preliminary or emerging behaviors before the targeted are witnessed, pertinent history relating to the behaviors, possible causes of the behaviors, and an evaluation of the environments where targeted behaviors take place.

Intervention

Intervention units can be added to Residential and Day Habilitation services when a participant's regular supervision level may not provide sufficient staffing for specific activities included in the Plan of Care, but the supervision level is not needed at all times.

Medication Assistance Record (MAR)

Form containing the participant's name, allergies, medication name(s), dosage (including strength or concentration of the medication), administration route, special instructions, date and time of the medication assistance needed, and signature of the provider assisting with medications.

PRN

Medical term meaning a medicine given as the occasion arises, or when necessary.

Participant

An individual who has been determined eligible for covered services on the Waiver.

Person-centered planning

A process directed by a participant that identifies the participant's strengths, capacities, preferences, needs, services which may meet the needs, and providers available to provide services. Person-centered planning allows a participant to exercise choice and control over developing and implementing the plan of care.

Positive Interventions

An action by a person that changes a course of events or targeted behaviors by a participant, characterized by displaying approval, acceptance or affirmation.

Positive Behavior Supports

Multiple approaches with a person, such as changing systems, altering environments, teaching skills, and appreciating positive behavior, in hopes of avoiding a target behavior.

Protocol

A detailed plan of treatment, or procedures/directions to follow for a specific event, such as a medical, seizure, or behavior plan protocol.

Provider

A person or entity that is certified by the DDD to furnish covered services and is currently enrolled as a Medicaid Waiver provider.

Replacement behaviors

Acceptable behaviors and actions taught to a participant as an alternative way to communicate needs and wants, respond to a situation, event, or problematic environment rather than displaying the targeted behavior(s).

Restraint

A personal, mechanical, or drug used as to restraint as defined in Chapters 41- 45 of Medicaid rules.

Restriction

A condition that limits a right of a person, keeps a person or possession within certain boundaries, or controls behavior with a physical, mechanical, or a drug used as a restraint.

Staff

Any employee of a Medicaid provider, usually referring to a person who provides direct care to a participant.

Targeted behaviors

Specific behavior the participant or the team would like to change or extinguish. Things for the team to consider: *Does the current behavior impact the goals of the plan? What behavior should replace it? What incentive does participant have to implement the desired behavioral change? What is the desired outcome of the behavioral change, and how is this addressed in the plan of care?*

Task analysis

A method used to track measurement on a participant's objective. It should contain the objective statement, each task involved in achieving the objective, the level of support needed for completing a task, and a system to measure achievement on each task and overall measurement on the objective.